

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013509

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 1662

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) RESEARCH HOSPITAL		d. STREET ADDRESS 4804 JEFFERSON STREET	
Length of stay in lb 62 YEARS		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN FREDERICK REINHARDT		4. DATE OF DEATH MARCH 30, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 5, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		11. BIRTHPLACE (City and state or country) KANSAS CITY, MISSOURI	
13a. FATHER'S NAME FRANK JOSEPH REINHARDT		14. NAME OF HUSBAND OR WIFE MYRTLE E. REINHARDT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT MYRTLE E. REINHARDT-KANSAS CITY, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of the Liver</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Primary Carcinoma of the Colon</i> DUE TO (c) <i>Cholemia and Malnutrition</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Cholemia and Malnutrition</i>		INTERVAL BETWEEN ONSET AND DEATH 3 mos. 2 years 1538	
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at Jan 3-1959, to March 30-1959 and last saw him alive on March 30-1959 3:00 P. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Graham Asher M.D.	
22b. ADDRESS 1220 Professional Kansas City 6 - Mo.		22c. DATE SIGNED 4-3-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APRIL 1, 1959	23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS-K. C., MO.		25. DATE RECD. BY LOCAL REG. 4-1-59	26. REGISTRAR'S SIGNATURE Irlva Marshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Graham Asher

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Norman W. Thorsen

Licensed Embalmer No. 4889

P. O. Address N.C., No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.